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Addressing the persistence of female genital mutilation: Current situation and prospects for effective intervention

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Author Biography

Florence Chatot holds a degree in development anthropology from the École des Hautes Études en Sciences Sociales (EHESS). She began her career in France, working with public health research institutes, before moving into the international solidarity sector, with a particular focus on operational research and project evaluation. Her research interests include sexual and reproductive health and rights, gender issues, HIV/AIDS, mental health, and migration. A former research fellow at Groupe URD, she is now an independent consultant affiliated with the Epigreen expertise and research office and also lecturer at Aix-Marseille University.

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Introduction

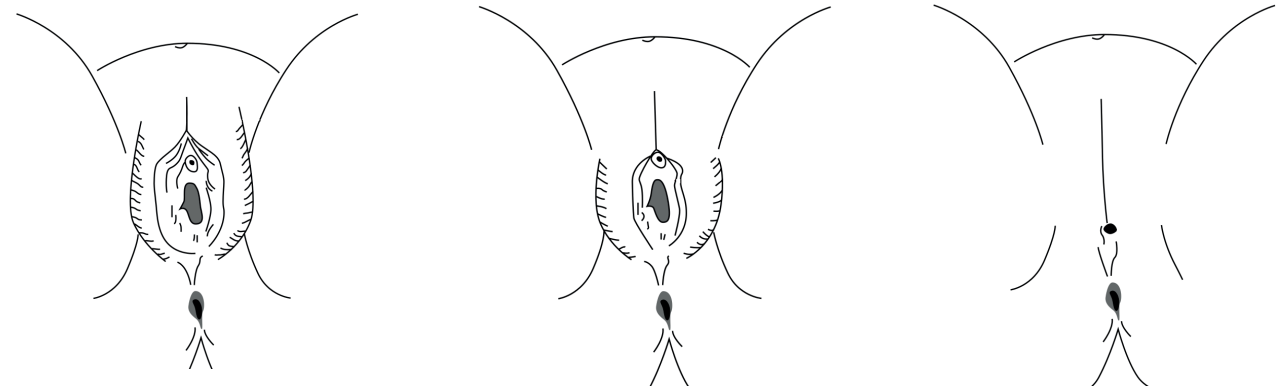
Drawing on operational anthropological research conducted in Chad, this article reviews the current situation with respect to female genital mutilation, analyzes the factors contributing to the persistence of the practice in certain contexts, and offers recommendations to more effectively fight against it.

Definition and consequences

Female genital mutilation (FGM) refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (WHO 1997). The term can refer to four different types of mutilation:

- **Type 1**: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy);
- **Type 2**: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision);
- **Type 3**: Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris (infibulation);
- **Type 4**: All other harmful procedures to the female genitalia for non-medical purposes.

Figure 1 - Types of FGM practiced worldwide



Type I
Removal of the prepuce and the clitoris

Type II
Removal of the clitoris and the labia minora

Type III
Infibulation

Source: adapted from World Health Organization. 2014. "Female genital mutilations".

FGM has severe consequences for women's sexual, reproductive, and psychological health. It results in two main categories of complications (Andro and Lesclingand 2016):

- **Immediate risks** that occur at the time of the act itself (including pain, bleeding, infection, and trauma);
- **Long-term risks** that can arise at any time in life (such as urinary disorders, infections of the reproductive system, sexual pain and dysfunction, obstetric complications, and lasting psychological effects).

Reproductive health research shows that women who have undergone FGM face greater obstetric risks in cases of Caesarean section, postpartum hemorrhage, and neonatal respiratory distress. According to a World Health Organization (WHO) study conducted in six African countries in the early 2000s, neonatal mortality is twice as high among women who have undergone FGM (Banks *et al*. 2006). Two factors exacerbate this situation. First, the more invasive the procedure (and therefore the more tissue damaged), the more severe the health repercussions. Second, the consequences of FGM are more serious when the procedure is carried out in lower-quality healthcare systems that are unable to manage the resulting complications.

FGM is, therefore, a violation of several fundamental rights: the right to security and physical integrity; the right to be free from torture and cruel, inhuman, or degrading treatment or punishment; and, when the consequences of FGM are fatal, the right to life.[1] Hence, the 2030 Agenda for Sustainable Development, adopted in 2015, explicitly calls for the elimination of FGM in Goal 5.3: "Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation."[2]

Study overview and methodology

While numerous international aid interventions have targeted FGM, these efforts have at times proven inefficient or even ineffective. Drawing on data collected through operational research funded by AFD, this article explores strategies to effectively combat FGM and offers recommendations for development actors.

The socio-anthropological study[3] that this article is based on was conducted between January and May 2020 in the Mandoul region of Chad, where FGM remains widespread, with a prevalence

[1] United Nations. 2003. "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)." In *Combating Torture*. Geneva, New York: Office of the United Nations High Commissioner for Human Rights. https://www.ohchr.org/Documents/Publications/FactSheet4rev.1en.pdf.

[2] See https://www.un.org/sustainabledevelopment/gender-equality/.

[3] See Chatot 2020.

rate as high as 80.4%.[4] The study was carried out as part of the *Projet d'autonomisation sociale des femmes par l'accès aux services de santé maternelle et reproductive au Tchad* (PASFASS) (Project for the Social Empowerment of Women through Access to Maternal and Reproductive Health Services in Chad). It falls within the domain of applied research and is intended to produce practical knowledge for development professionals to help make sustainable improvements to their interventions.

The study's primary data collection tools were semi-structured interviews and focus groups. A total of 60 interviews and 5 focus groups were conducted, then transcribed, coded, and analyzed for robust data triangulation.

A recommendation follow-up matrix was developed and shared with project partners. Regular exchanges between operational actors and the research team took place over several months to monitor the implementation of the recommendations and adapt activities and resources for new interventions. This iterative approach, which is characteristic of operational research, made it possible to propose intervention methods tailored to the particular social contexts that FGM was occurring in, and thereby to directly apply the study's findings. In addition, the production of a documentary film on the persistence of FGM that featured the perspectives of all actors involved in the practice, whether they were opposed to it or in favor of it, helped improve the transmission and dissemination of the study's findings.[5]

[4] « Enquête par grappes à indicateurs multiples » (MICS6-Tchad, 2019).

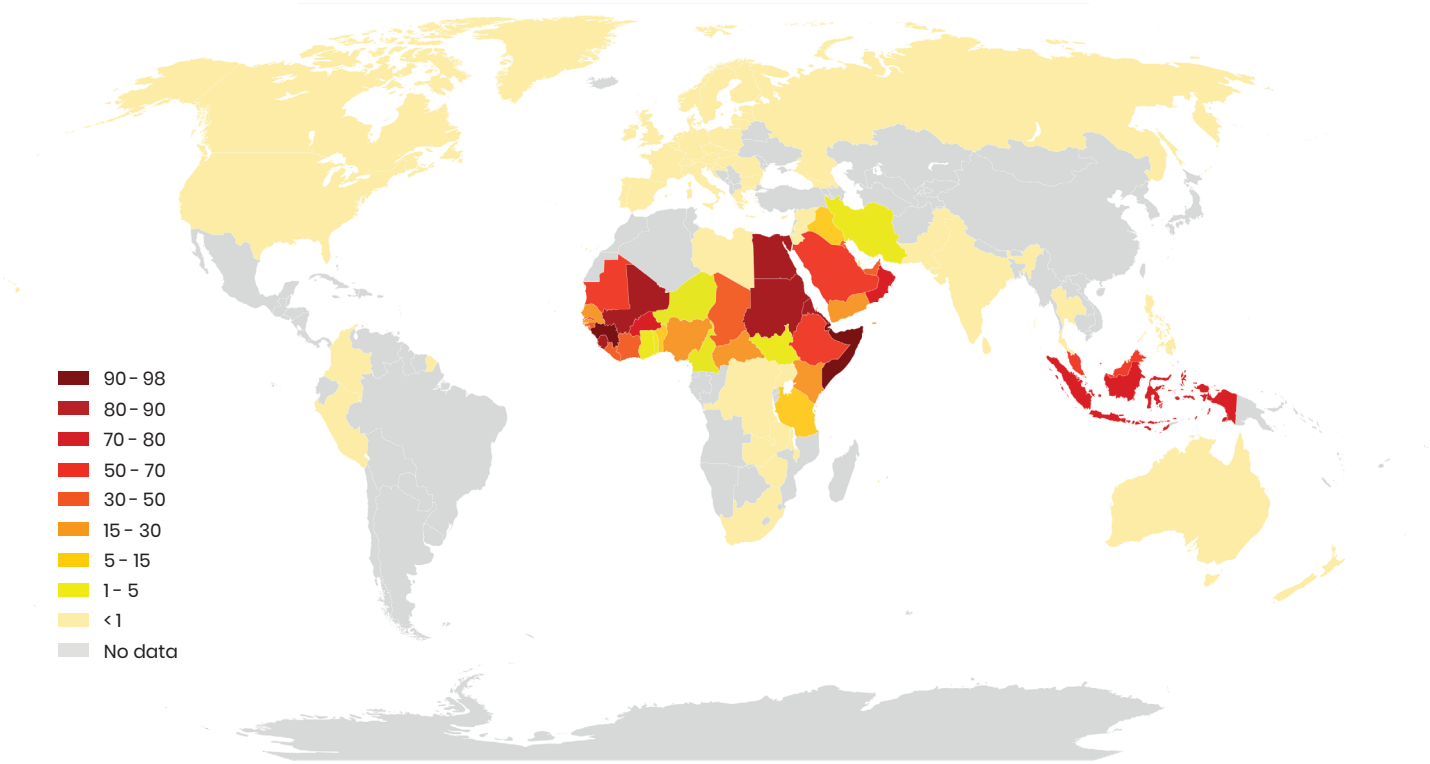
[5] The documentary film *La jeune fille, les chouettes et les hommes lions. Pourquoi l'excision persiste dans le Mandoul*, was directed by Carol Valade. It is available at: https://www.youtube.com/playlist?list=PL5ykm1TNSyakEzcPlC4ctiFzD7qjhFDbp. See also https://www.urd.org/fr/actualite/103218/.

1.
Current situation of FGM worldwide

1.1 – A practice that is declining but remains deeply rooted

According to UNICEF, over 230 million women and girls alive today have been subjected to FGM. Of these, 144 million live in Africa, 80 million in Asia (Indonesia, Malaysia, and the Maldives), 6 million in the Middle East (Iraq and Yemen), and an estimated 1 to 2 million in small practicing communities and countries of migration elsewhere in the world (UNICEF 2024). FGM has been documented in 31 countries. In Africa, 27 countries spanning the middle of the continent from west to east, including Egypt, are particularly affected (Andro and Lesclingand *op. cit.*), although prevalence levels vary widely. National figures often mask significant regional disparities, and the extent of the practice can differ substantially within a single country.

Map 1 - Percentage of women aged 15 to 49 years who have undergone female genital mutilation worldwide



Source: Nederlandse Leeuw 2020 (data: END FGM European Network, END FGM/C US Network et Equality Now. 2020. *Female Genital Mutilation/Cutting: A Call For A Global Response*. https://www.endfgm.eu/editor/files/2020/04/FGM_Global_-_ONLINE_PDF_VERSION_-_07.pdf.).

Note on Map 1: As the quality of data varies widely from country to country, the report proposes a categorization into four groups: countries with available data on FGM from nationally representative surveys (32 in total, category 1); countries with available data on FGM from indirect estimates (31 in total, category 2); countries with available data on FGM from small-scale research studies (15 in total, category 3); countries with available data on FGM from media reports and anecdotal evidence (14 in total, category 4).

The color beige is used to indicate either that FGM rate in a given country has been determined to be below 1%, is estimated to be below 1% (e.g. based on the fact that it has only been observed in a single or few small ethnic groups that comprise less than 1% of the country's population), or where the prevalence rate is unknown even though FGM has been demonstrated to occur in that country. This includes countries like Brunei where prevalence is thought to be very high (due to religious and political factors) and countries like Colombia where prevalence is thought to be very low (due to ethnic demographic factors). This separates these countries from countries without any data at all (grey).

Changes in FGM rates vary widely across countries. Among the 31 countries where the practice has been documented, rates have either halved or declined by at least 30% over the past three decades in 10 countries.[6] Another 10 countries have seen notable though less dramatic reductions.[7] In 5 countries, however, little to no progress has been recorded.[8]

Following developments in the international normative framework, 25 countries have enacted legislation or issued decrees to prohibit or restrict FGM in recent decades.[9] However, signatory states struggle to enforce these laws, which often conflict with pre-existing social norms and local dynamics. According to the WHO, the global economic cost of managing the health complications caused by FGM is estimated at USD 1.4 billion per year. This figure could rise to USD 2.3 billion over the next 30 years if FGM rates stay the same.[10] Conversely, the abandonment of FGM could reduce these costs by as much as 60% over the same period.

1.2 – The gradual establishment of an international normative framework

The movement to eliminate FGM is grounded in the principles of human rights, the right to health, and the rights of women and girls. It has developed, in stages, over a period of decades. Before its integration into the 2030 Agenda for Sustainable Development, numerous international treaties addressed the practice of FGM. Three key instruments have played a particularly significant role in shaping the normative framework:

- **The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**: Adopted in 1979 by the United Nations General Assembly, CEDAW was one of the first international legal texts to explicitly promote the protection of women's rights. Since 1990, the United Nations General Assembly has adopted a series of resolutions on the elimination of harmful practices that seriously threaten the health of women and girls. The most recent resolution, adopted on December 15, 2022, calls on member states to step up global efforts to eliminate female genital mutilation (A/RES/77/195).[11]
- **The Cairo Declaration for the Elimination of FGM**: While some countries have not ratified the CEDAW,[12] or any other treaty that explicitly mentions FGM, the vast majority endorsed the Cairo Declaration on the Elimination of FGM in 2003.[13]
- **The Maputo Protocol**: At the regional level, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol, was adopted in 2003. Article 5 explicitly calls on signatory states to engage in the "prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation."[14] The protocol has been signed by the vast majority of African states.

[6] Sierra Leone, Burkina Faso, Ethiopia, Liberia, Maldives, Nigeria, Kenya, Benin, Tanzania, and Iraq (UNICEF 2024).

[7] Guinea, Egypt, Djibouti, Eritrea, Sudan, Mauritania, Côte d'Ivoire, Central African Republic, Yemen, and Chad (UNICEF 2024).

[8] Somalia, Mali, Gambia, Guinea-Bissau, and Senegal (UNICEF 2024).

[9] "Law Factsheet 1: International and Regional Treaties Relevant to FGM." See https://www.28toomany.org/thematic/law-and-fgm.

[10] Estimated cost for 2018 for 27 countries where data is available. See World Health Organization. 2025. "Female Genital Mutilation". *Who.int*. January 31, 2025. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation.

[11] United Nations General Assembly. 2022. "Resolution 77/195: Intensifying Global Efforts for the Elimination of Female Genital Mutilation." December 15, 2022. See https://docs.un.org/en/A/RES/77/195.

[12] UN Women. n.d. "General Recommendation No. 14 (Ninth Session, 1990): Female Circumcision". In *General Recommendations Made by the Committee on the Elimination of Discrimination against Women*, Convention on the Elimination of All Forms of Discrimination Against Women. https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom14.

[13] 25 out of 29 countries have adopted the declaration: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Tanzania, Togo, and Uganda. See The National Council for Childhood and Motherhood 2003.

[14] African Union. 2003. *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*. Maputo. https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf.

1.3 – The origins of the practice

Although the origins of FGM remain somewhat unclear, it is well established that the practice predates the emergence and spread of Islam in Africa, although religious justifications have since been invoked to legitimize the practice. As Françoise Couchard (2003) notes, unlike male circumcision—which, in both Judaism and Islam, signifies the covenant between God, Abraham, and Abraham's descendants—FGM is not prescribed in the sacred texts of the major monotheistic religions.

According to Gerry Mackie (1996), FGM originated along the west coast of the Red Sea, in present-day Egypt, and later spread to surrounding regions in southern and western Africa. Infibulation, the most invasive form of FGM, occurs mainly in eastern Africa, in Eritrea, Djibouti, Somalia, Egypt, and Sudan. Infibulation has been linked to the trade in female slaves during the expansion of Islam on the continent (Andro and Lesclingand *op. cit.*; Mackie and LeJeune 2009). This extreme form of FGM, whose name comes from the Latin *fibula* (meaning "pin" or "brooch"), was reportedly used on female slaves in ancient Rome to prevent them from engaging in sexual activity and becoming pregnant, as motherhood would have rendered them unable to work (Hosken 1982). Clitoridectomy, meanwhile, was first observed in Europe, where it emerged in the context of repressive medicalization of sexuality. The procedure was promoted by the British physician Isaac Baker-Brown, who advocated it as a means of combating female masturbation and hysteria (Sindzingre 1979). Although Baker-Brown was eventually discredited by the medical community in 1867, the practice continued in the United States until the late 1960s (Andro and Lesclingand 2016).

1.4 – Multiple resistance factors

Over time, the practice of FGM has spread to various parts of the world and taken on new forms, shaped by symbolic, social, and economic justifications.

- **Symbolic factors.** Respect for myths and ritual traditions is one of the primary justifications for the continuation of the practice and plays a significant role in its persistence. "Symbolically, a woman who has not undergone FGM is not yet purified of her masculine attributes: she is therefore not really a woman and remains stuck in the uncertainty of her status as a child" (Chatot 2020). In some countries, the practice has become detached from any social or symbolic function, but in others, it remains closely linked to initiation rites or "rites of passage." These rites, which have been studied extensively by anthropologists since the early twentieth century,[15] serve a unifying social function: "To be initiated is to be part of a very specific group, where membership is sometimes marked in the flesh."[16] Puberty-related initiation rites serve to condition the individual by instilling a set of prescribed rules (Chatot 2020). They elevate girls to the status of "full" members of their group through a socially valued sexual status.
- **Social factors.** Undergoing FGM is synonymous with integration into a community. It "is always based on the construction of a gender identity and determines the social relations between the sexes that are expected and promoted within society" (Chatot 2020). As a result, someone who refuses or avoids the practice may be excluded from society. In communities that practice FGM, the social stigma directed at women who have not undergone the procedure is often conceived of as worse than the physical pain of the act itself. From this perspective, parents who continue to subject their daughters to FGM do so in an effort to "protect" them from ostracism and secure their prospects for marriage.

[15] See on this subject: Arnaud D, Chaperon S, Clastres P, Sindzingre N, Fainzang S, Héritier F, Godelier M, Griaule M, Lescingand M, Mackie G, Petit V, Andro A, Shell Duncan B, Turner V, Van Gennep A, Vissandjée B.

[16] Université de La Réunion. *Le rituel et le matériel.* https://www.anthropologieenligne.com/.

- **Economic factors**. The practice has a cost that in itself justifies the existence of an FGM economy: "Far from being limited to the strictly female interaction between the exciser and the excisee, FGM involves a number of people in the community who, due to their social function in the rite and the income they derive from it, legitimise the fact that the practice persists" (*ibid.*). These economic actors are diverse and vary according to context. In cases where FGM is medicalized, health professionals are more often the beneficiaries. Where the practice is customary and tied to initiation rites, it is traditional authorities and female practitioners who profit most from the procedure.

2. Recommendations

Toward better contextualized interventions, grounded in rigorous field research that takes social dynamics and local representations into account

In response to the persistence of FGM, and in line with the growing emphasis on the international human rights agenda, numerous interventions to reduce FGM rates have been proposed, funded, and implemented in recent years by local organizations, donors, international NGOs, and governments. However, the effectiveness of these interventions has, at times, been restricted by the complexity of the issue and an often limited understanding of the practice.

This is where research can inform action: It can offer new insights into the persistence of FGM and the forms of action needed to address it. With its in-depth, localized focus, action research functions like a magnifying glass for examining the specificities of a particular social setting and enabling a better analytical understanding of broader dynamics. Studying the unique characteristics of a given context enables us to identify patterns that recur across different spaces and social groups—in other words, to extrapolate from the particular to the general and from the local to the global.

Although initially intended for actors in Chad, the recommendations presented here contribute to a broader body of reflections on the effectiveness of efforts to eliminate FGM. Their relevance therefore extends beyond this highly localized context to all development actors: technical and financial partners; local and international NGOs; and civil society organizations engaged in the fight against FGM, including local associations and activist groups. Governments that have launched or would like to develop interventions to combat FGM will also find useful avenues for action in these recommendations.

Box 1. Sociocultural and historical determinants of the persistence of FGM in Chad

The study presented here, conducted in Chad's Mandoul region, notes that the majority of women from the Sara ethnic group have been subjected to FGM. However, while initiation is considered a key rite of passage among this group, the study shows that FGM is not an ancestral practice. It appears to have been incorporated into the female initiation rite in the early twentieth century. Female initiation without FGM, known as *Ndo Gor*, predates *Bayan* (initiation with FGM) and continues to be practiced by certain ethnic groups in Mandoul and Logone Oriental. Over time, the initiation rite evolved as a result of population movements. In the 1970s, during Chad's post-independence period, the ritual was also appropriated for political purposes: François Tombalbaye, Chad's first president and himself a member of the Sara ethnic group, used traditional initiation rites as a means of political coercion. In an effort to consolidate power in the face of rebellion from the Muslim North and pressure from the former colonial power, he imposed initiation practices on all of the country's ethnic and religious groups. Men and women across Chad were compelled to undergo initiation under threat of reprisals. This "revival" increased FGM rates in Chad.

In addition to the weight of history, other social and customary factors help sustain FGM rates in the country. Among the Sara ethnic group, there is a belief—falsely attributed to custom—that only a woman who has undergone FGM may prepare meals for men during *Yondo*, the male initiation rite. This belief creates an intrinsic link between the female and male initiation rites. This requirement is a relatively recent innovation, however: Historically, neither the female nor the male initiation rite involved FGM. Far from being a minor detail, the link between these rites is yet another barrier to ending the practice in the Sara community, which is Christian and which constitutes the majority of the population in the Mandoul region.

On this point, the study notes that "custom" and "tradition," though they tend to be viewed as timeless and immutable, are in fact dynamic and subject to change.

It is therefore essential to examine the historical and social context, as well as the collective representations associated with the practice, in order to deconstruct the "false beliefs" that may sustain the practice.

2.1 – Recommendation 1: Avoid standardizing interventions

The prevalence and persistence of the practice vary significantly across geographical and socio-ethnic contexts. Solutions must account for these differences and break with the often ineffective practice of employing standardized interventions. As Chatot (*op. cit.*) argues, "we must be able to understand the phenomenon before attempting to transform it. We believe that the situation concerning FGM is sufficiently alarming and complex that it deserves to be treated in a more objective and localised manner, that is to say, closer to the individuals who practise it."

The research conducted in Chad underscores the influence of specific socio-ethnic factors on the persistence of FGM and highlights the need for civil society organizations (CSOs) to tailor their responses accordingly. The study recommends, for example, that donors and NGOs avoid "blindly" replicating "out of touch" interventions that were developed and implemented in other countries or sociopolitical contexts.

One such intervention involves encouraging FGM practitioners to transition into other lines of work, a strategy that CSOs often use in other settings. These initiatives offer financial compensation by providing alternative income-generating activities in exchange for the abandonment of FGM. Financial incentives can be an effective way of encouraging changes in practice in other health programs, such as financial compensation for people taking part in HIV/AIDS screenings. However, this approach has obvious long-term limitations, and when applied to FGM, it tends to be entirely ineffective. In contexts of systemic poverty, FGM practitioners may opt to pursue both income sources simultaneously, continuing to perform FGM alongside their new activities. Furthermore, FGM practitioners are not the only people involved in the practice, which makes it unrealistic to attempt to "reconvert" all actors involved in the FGM economy. This example points up both the shortcomings of a standardized approach and the importance of rigorous, context-sensitive field research. One of the study's recommendations is to redirect funds initially allocated for practitioner reconversion to public awareness campaigns and advocacy programs, which are more effective and help foster long-term behavioral changes.

2.2 – Recommendation 2: Abandon Western-centric discourse

Western narratives that describe FGM as "barbaric" or "primitive" often stigmatize the people involved in the practice rather than sensitize them to its negative impact. These narratives can be counterproductive by reinforcing conservative positions among defenders of FGM. Although the fight against FGM should certainly involve denouncing the practice, the rhetoric employed can determine the impact of the message. Western indictments of African customary practices are rarely perceived as legitimate or persuasive by the communities concerned.

As Armelle Andro and Marie Lesclingand (*op. cit.*) note, "efforts to combat the practice can have unintended consequences when they result in the imposition of hegemonic social norms." In fact, interventions led by external actors are more effective when they are implemented in collaboration with local associations and national feminist movements, because women in these countries are the most credible, knowledgeable actors in the fight against FGM.

In Chad, many women-led Chadian organizations[17] are engaged in the daily work of combating FGM through advocacy, awareness campaigns, and survivor support. One of the study's main recommendations to international NGOs and donors is therefore to build upon these endogenous efforts by giving Chadian actors the resources to sustain their activism over the long term.

[17] Such as the Comité national du Comité interafricain pour la lutte contre les pratiques néfastes à l'égard des femmes et des enfants (CONACIAF) (National Committee of the Inter-African Committee for Combating Harmful Practices Against Women and Children), the Association des femmes juristes du Tchad (AFJT) (Association of Women Lawyers of Chad), the Cellule de liaison et d'information des associations féminines (CELIAF) (Women's Associations' Information and Liaison Group), the Bureau d'appui Santé et Environnement (BASE) (Health and Environment Support Bureau), and the Croix Rouge tchadienne (CRT) (Chadian Red Cross).

The study also recommends identifying a "godmother" and a "godfather" from among respected figures in the Chadian arts/culture/sports sectors to help amplify public awareness campaigns and bring them national visibility.

2.3 – Recommendation 3: Develop a holistic approach to combating FGM

Efforts to eliminate FGM may be less effective if they focus solely on the health or legal consequences of the practice. Two new trends appear to be gaining traction in communities where FGM persists:

- **The medicalization of the practice** is intended to reduce the physical suffering associated with FGM by involving health professionals before and after the ritual (such as to provide painkillers and antibiotics). This shift toward a more "acceptable" form of FGM, akin to a harm reduction strategy,[18] is concerning. While medicalization may reduce immediate health risks, it does not address the long-term physical and psychological consequences of the practice. Emphasizing health risks alone could lead to the increased medicalization of FGM rather than its abandonment.
- **The criminalization of FGM** is an undeniable step forward in terms of public health and human rights. However, it can unintentionally drive the practice underground and thereby increase the risks faced by girls. If complications arise, the people involved may be less likely to seek medical assistance for fear of legal repercussions. For this reason, awareness campaigns and community engagement are likely better strategies.

[18] Harm reduction is a public health and health promotion strategy developed primarily in response to the HIV/AIDS epidemic among people who inject drugs. It is a policy approach aimed at preventing the health and social harms associated with drug use. The strategy is based on the understanding that drug users are capable of modifying their behaviors when provided with supportive tools and options. Harm reduction programs typically include access to sterile syringes, as well as screening (for example for HIV and hepatitis C) and medical care. See: https://sante.gouv.fr/prevention-en-sante/addictions/article/la-reduction-des-risques-et-des-dommages-chez-les-usagers-de-drogues.

Effective interventions must address all the interrelated drivers of FGM. In addition to health and legal considerations, responses should account for other types of consequences, such as impacts on family livelihoods, mental health, marital relationships, and girls' access to education.

One of the recommendations that emerges from this analysis is to strengthen community-based awareness campaigns that target all national and provincial state actors, as well as civil society organizations involved in the fight against FGM, such as international and local NGOs, local associations, and women's groups. Specifically, this involves:

- Establishing provincial and national networks to combat FGM that involve existing local organizations;
- Organizing training sessions that address the historical, social, religious, physical, and psychological dimensions of FGM for all provincial actors, including state services, CSO staff, public and private health training institutions, health and legal institutions, customary authorities, traditional practitioners, traditional midwives, and teachers;
- Implementing awareness campaigns in schools that engage "peer leaders" (both girls and boys) to disseminate key anti-FGM messages. Organizing sports and cultural events aimed at young people can also help demystify the practice through recreational methods.

2.4 – Recommendation 4: Identify collective perceptions of FGM using an approach based on "rumors"[19]

One of the methods used in the operational research conducted in Chad involved identifying the perceptions of FGM held by men, women, and teenage boys and girls. The researchers asked members of partner CSOs to organize focus groups with participants from each of these groups. The underlying goal was to collect data on "village

[19] See, for example, Aldrin 2005.

rumors" circulating in the community in order to better understand how collective perceptions and attitudes toward FGM are shaped by these rumors.

There are two advantages to the approach based on rumors. First, it allows respondents to depersonalize the topic of FGM and thus to speak indirectly by referencing other people's practices and perceptions. Participants might be asked a question such as "What rumors are going around about women who have or have not been subjected to FGM?" Second, it makes it possible to draw up a typology of stereotypes commonly associated with the practice.

In the context of operational research, it is essential for project teams to identify and analyze these stereotypes. Understanding the social representations of FGM allows actors on the ground to tailor their messaging and awareness campaigns more effectively in order to change behaviors. In other words, knowing what rumors are going around is the first step toward putting them to rest.

2.5 – Recommendation 5: Inform and involve men in the fight against FGM

Contrary to popular belief, men are not always staunch defenders of FGM. In Chad's Mandoul region, qualitative data collected from interviews show that some men oppose the practice, including customary and state leaders, law enforcement officials (such as lawyers and deputy prefects), healthcare providers, and teachers.

FGM remains a taboo subject among men, which makes it difficult to conduct a sufficient number of interviews to draw significant conclusions. However, the documentary film produced on the basis of the study[20] shows that certain men reject FGM. It is interesting to note that the reasons men cite for rejecting the practice often differ from those expressed by women. In addition to concerns about the health consequences for their wives and daughters, men point to the impact of FGM on marital intimacy. Husbands describe how their wives' trauma-related fear of sexuality, reduced pleasure, pain during intercourse, or chronic urinary issues—all of which are linked to FGM—can undermine their marriage.

Economic considerations also appear to influence men's willingness to abandon the practice. As the primary financial providers, men are often responsible for covering the costs associated with the ritual, including payments to FGM practitioners, customary chiefs, attendants, and caregivers, as well as expenses for food, clothing, and medicine.

Finally, the interviews reveal that fathers are often unfamiliar with the health consequences of FGM for their daughters. Few of the men interviewed could name more than one harmful effect of the practice. One customary chief, for example, explained that he became aware of its long-term effects only when a female community educator showed him images of particularly disabling genital mutilation. In his view, this lack of information about the causes and consequences of FGM is a barrier to men's engagement in efforts to end the practice.

The study thus suggests that while a minority of men already oppose FGM and speak out about its harmful effects on women's health and on their marriages, other men would likely join them if they were better informed. Men can be important allies in the fight against FGM and should therefore be systematically included in awareness and advocacy efforts. Furthermore, anti-FGM messaging should be tailored to men's specific concerns and information needs. Finally, to be as effective as possible, awareness activities targeted at men and adolescent boys should take place in their prefered gathering places, such as associations, places of worship, movie theaters, bars, youth centers, and sports stadiums.

[20] See the documentary film on FGM in Mandoul: https://www.youtube.com/playlist?list=PL5ykm1TNSyakEzcPIC4ctiFzD7qjhFDbp.

2.6 – Recommendation 6: Support efforts to break the silence around FGM

Reducing FGM in Chad and other countries requires long-term efforts. That said, one of the most encouraging trends revealed in these interviews is the growing openness to speak out against the practice. For example, two books[21] written by Chadian women campaigning against FGM recount their personal experiences with the practice and denounce its impact on girls' reproductive health and education. Throughout the research process, many women expressed a desire to share their views on the subject. Notably, some grandmothers, who are typically seen as guardians of tradition, openly rejected FGM[22] and refused to allow their granddaughters to undergo the procedure. According to representatives of local anti-FGM associations, both women and men who had previously remained silent in their opposition to the practice are breaking a long-standing social taboo and beginning to speak out.

The study therefore reveals that while they may not be statistically measurable, micro-changes are occurring within households. More people speaking out on the issue is an undeniably positive sign, and anti-FGM efforts can be anchored and sustained by building on these micro-changes.

It is therefore crucial that individuals who are willing to speak out be given platforms to do so. Community forums, mobile cinema campaigns, theater performances, documentary screenings, focus groups, radio broadcasts, and training programs for health, social, legal, and customary actors have all proven effective in various contexts. Changing practices and social norms, however, is a long process. The international donors who finance these projects and the local actors who implement them should therefore consider how to ensure the continuity and sustainability of funding. To achieve their full potential, efforts to combat FGM must be designed and implemented with a long-term perspective.

[21] Célestine Nemadji. 2018. *L'excision et la déperdition scolaire des filles au Tchad.* Edilivre; Bayor Chantal Ngoltoingar. 2016. *L'obscurité sous le soleil. Afrique – Tchad – Monde.* Edilivre.

[22] See the documentary film on FGM in Mandoul: https://www.youtube.com/playlist?list=PL5ykm1TNSyakEzcPIC4ctiFzD7qjhFDbp.

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